SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Filing at a Glance

Company: Life Insurance Company of Alabama

Product Name: Term Life Policy	SERFF Tr Num: WAKE-126761415	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46444
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: KEGLOATLAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Toni Hess, Katlyn Gorman, Austin Taylor, Michelle Miller, Ben Cohen	Disposition Date: 08/11/2010
	Date Submitted: 08/09/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Company of Alabama
Project Number: KEGLOATLAR
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/11/2010

Deemer Date:
Submitted By: Katlyn Gorman
Filing Description:
Please see cover letter under Supporting Documentation tab.

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This filing is currently pending in the home domicile state of Alabama as of now.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/11/2010
Created By: Katlyn Gorman
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Company and Contact

Filing Contact Information

Katlyn Gorman, Administrative Assistant
34125 US Highway 19 North
Suite 310
Palm Harbor, FL 34684

katlyn.gorman@wakelyactuarial.com
888-590-5504 [Phone] 2100 [Ext]
727-373-4559 [FAX]

Filing Company Information

(This filing was made by a third party - WAS01)

Life Insurance Company of Alabama	CoCode: 65412	State of Domicile: Alabama
302 Broad Street	Group Code: -99	Company Type:
Gadsden, AL 35901	Group Name:	State ID Number:
(256) 543-2022 ext. [Phone]	FEIN Number: 63-0321291	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	Yes
Fee Explanation:	$50.00 per form X 3
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of Alabama	$150.00	08/09/2010	38614442

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/11/2010	08/11/2010

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Disposition

Disposition Date: 08/11/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization Letter		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	AR Rule 19 Certification		Yes
Form	Term Life Insurance Policy		Yes
Form	Application for Life Insurance		Yes
Form	Waiver of Premium Disability Rider		Yes

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Form Schedule

Lead Form Number: LT300

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LT300	Policy/Contract/Fraternal Certificate	Term Life Insurance Policy	Initial		55.900	Term Policy Form LT300.pdf
	MP LIFE 7-10	Application/Enrollment Form	Application for Life Insurance	Initial		40.700	MP LIFE 7-10.pdf
	WP LT300	Other	Waiver of Premium Disability Rider	Initial		44.600	Term Waiver Rider Form WP LT300 .pdf

LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

READ THIS POLICY CAREFULLY!

LIFE INSURANCE COMPANY OF ALABAMA will pay the Proceeds of this policy to the beneficiary immediately upon receipt of due proof of the Insured's death.

This policy is made in consideration of the application for this policy, a copy of which is attached, and in consideration of the payment of premiums as provided herein, for the full premium paying period as stated herein or until the prior death of the Insured.

WE SIGNED this at our Home Office in Gadsden, Alabama on the Policy Date.

Secretary President

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy, it may be cancelled on or before the 30th day after its receipt by delivering or mailing it to our Home Office or to the agent through whom it was purchased. Immediately upon such delivery or mailing, this policy will be treated as if it never existed. Any premium paid will be refunded within 10 days after we have received this policy.

INQUIRIES

You may obtain information regarding Your coverage or request assistance in resolving complaints by writing to the home office at P.O. Box 349 Gadsden, AL 35902.

NOTICE

This policy is valuable property. If anyone suggests replacing it, please contact Us first to be certain of Your rights and values.

When You write to Us, please give Us Your name, address and policy number. Please notify Us promptly of any changes. We will write to You at Your last known address.

TERM LIFE INSURANCE POLICY

Proceeds payable if the Insured dies while this policy is in force
Premiums payable during Premium Period or Until Insured's Prior Death
Renewable as Provided Herein
Nonparticipating

POLICY INDEX

A copy of application, any rider benefits, and any endorsements are attached after Page 9.

POLICY SCHEDULE

DESCRIPTION OF BENEFITS

FORM	BENEFIT	UNITS	BENEFIT AMOUNT
LT300	TERM LIFE POLICY		$100,000.00
WP LT300	WAIVER OF PREMIUM DISABILITY		

PREMIUM SCHEDULE

AVAILABLE PREMIUM PAYMENT FREQUENCIES

BENEFIT	ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	SPECIAL MONTHLY	PREMIUM PERIOD	EXPIRY DATE
TERM	163.00	84.76	43.20	14.67	13.58	[10] YEARS	*
WAIVER	13.00	6.76	3.45	1.17	1.08	{10] YEARS	1-1-2020
TOTAL	176.00	91.52	46.65	15.84	14.66		

PREMIUM PAYMENT FREQUENCY CHOSEN: SPECIAL-MONTHLY

*** AT END OF [10] YEARS, POLICY MAY BE RENEWED IN ACCORDANCE WITH PROVISIONS EXPLAINED IN THE TABLE OF GUARANTEED RENEWAL PREMIUMS SHOWN ON PAGE 4.**

POLICY INFORMATION

POLICY NUMBER:	SPECIMEN	POLICY DATE:	JANUARY 1, 2010
INSURED:	JOHN DOE	FACE AMOUNT:	$100,000.00
AGE AT ISSUE:	*35	STATE OF ISSUE:	ALABAMA
SEX:	MALE	RISK CLASS	PREFERRED

*** THE AGE AT ISSUE IS BASED ON THE INSURED'S LAST BIRTHDAY.**

POLICY NUMBER:	**SPECIMEN**	**POLICY DATE:**	**January 1, 2005**
INSURED:	**JOHN DOE**	**FACE AMOUNT:**	**$100,000.00**
AGE AT ISSUE:	***35**	**STATE OF ISSUE:**	**ALABAMA**
SEX:	**MALE**	**RISK CLASS:**	**PREFERRED**

********************* RENEWAL PROVISION **********************

AT THE END OF [10,15,20,30] YEARS AFTER THE POLICY DATE, YOU MAY RENEW THIS POLICY UP TO THE ANNIVERSARY FOLLOWING THE INSURED'S 95TH BIRTHDAY. THE PREMIUMS YOU PAY WILL INCREASE EACH YEAR AS SHOWN IN THE TABLE OF GUARANTEED RENEWAL PREMIUMS BELOW.

WE WILL NOT REQUIRE EVIDENCE OF INSURABILITY.

WE WILL ALLOW 31 DAYS AFTER THE END OF EACH POLICY ANNIVERSARY TO HAVE THIS POLICY RENEWED. IF THE INSURED DIES DURING THIS PERIOD, WE WILL AUTOMATICALLY RENEW THE POLICY AND DEDUCT ANY PREMIUM DUE FROM THE DEATH PROCEEDS.

****************** TABLE OF GUARANTEED ANNUAL RENEWAL PREMIUMS *******************

POLICY YEAR	INSURED'S ATTAINED AGE	ANNUAL PREMIUM	POLICY YEAR	INSURED'S ATTAINED AGE	ANNUAL PREMIUM
21	55	$2,088.00	41	75	$14,768.00
22	56	2,319.00	42	76	16,315.00
23	57	2,543.00	43	77	18,115.00
24	58	2,767.00	44	78	20,205.00
25	59	3,029.00	45	79	22,547.00
26	60	3,348.00	46	80	25,158.00
27	61	3,736.00	47	81	27,998.00
28	62	4,188.00	48	82	31,005.00
29	63	4,682.00	49	83	34,289.00
30	64	5,196.00	50	84	37,940.00
31	65	5,732.00	51	85	42,001.00
32	66	6,275.00	52	86	46,468.00
33	67	6,842.00	53	87	51,296.00
34	68	7,440.00	54	88	56,428.00
35	69	8,113.00	55	89	61,813.00
36	70	8,897.00	56	90	67,176.00
37	71	9,849.00	57	91	72,456.00
38	72	10,962.00	58	92	77,987.00
39	73	12,135.00	59	93	83,819.00
40	74	13,395.00	60	94	89,964.00

INTEREST ON DEATH PROCEEDS IS [8.0% PER ANNUM, PAYABLE FROM DATE OF DEATH IF CLAIM IS NOT PAID WITHIN 30 DAYS FROM THE DATE PROOF OF DEATH IS FURNISHED TO US.]

ANNUAL INTEREST RATE FOR REINSTATEMENT: [6.0%]

DEFINI

TIONS

We, Us, Our
The Life Insurance Company of Alabama.

You, Your
The owner of this policy. The owner's name and address is shown in the application.

The Insured
The person whose life is insured by the policy. The Insured's name is shown on Page 3.

Face Amount
The amount of insurance shown on Page 3, or on any endorsement to Page 3.

Age
The Insured's age on his/her last birthday.

Proceeds
The amount we are obligated to pay under the terms of this policy when the Insured dies. This amount may be less than the face amount if there is any indebtedness or a past due premium. It may be more if there are any riders attached to the policy which have payable death benefits.

Policy Date
The date this policy takes effect, as shown on Page 3.

Policy Month
A period beginning each month on the day of the policy date and ending the next month on the day preceding the day of the policy date.

Policy Anniversary
The same day and month as your policy date for each succeeding year the policy stays in force.

Policy Year
A period of twelve months beginning each year on the month and day of the policy date.

Written Request
A request in writing signed by you using the appropriate form provided by the company. All correspondence should be sent to our Home Office at P.O. Box 349, Gadsden, Alabama 35902. We may also require that the policy be sent in with your request.

Payee
The designated recipient of the Proceeds.

DEATH BENEFIT

Proceeds
If the Insured dies while this policy is in force, we will pay the Proceeds to the beneficiary.

The Proceeds are the sum of:

(a) the face amount of the policy at the time of the Insured's death; plus

(b) any insurance on the Insured's life that may be provided by riders to this policy; plus

(c) that portion of any premium paid which applies to a period beyond the policy month in which the Insured dies; minus

(d) any unpaid past due premium if death occurs during the grace period.

We will pay the Proceeds after we receive due proof of death and proper written claim. We may also pay interest on the Proceeds. A description of the interest we will pay on the Proceeds is shown on Page 4.

PREMIUMS AND REINSTATEMENT

Premium Payments
All premiums must be paid in advance of its due date. The first premium must be paid no later than when this policy is delivered. There is no insurance unless this premium is paid while all statements and answers in all parts of the application remain correct.

Each premium after the first must be paid on or before its due date.

Grace Period
We allow 31 days for the payment of any premium. This is called the Grace Period. It starts the day the premium is due. The policy is in force during the Grace Period. If the Insured dies during the Grace Period, we will deduct the past due premium from any amount we owe. If the premium is not paid before the end of the Grace Period, this policy may lapse.

Reinstatement
If a Grace Period has ended without payment of the premium due and this policy has terminated, you may apply to reinstate it. To reinstate this policy you must:

(a) apply in writing within 5 years after the end of the Grace Period; and
(b) provide due proof at your expense, at our underwriter's discretion that the Insured's health, occupation, and other risk factors have not materially changed since the policy date; and
(c) if approved for reinstatement, pay all overdue premiums plus interest, from their due dates to the date of reinstatement.

The reinstatement interest rate is shown on Page 4.

The date of reinstatement will be the first day of the Policy Month on or next following the date we approve your application for reinstatement.

When this policy is reinstated, a new 2 year contestable period will apply with respect to statements made in the application for reinstatement. This policy may not be reinstated if it has been surrendered.

Reserve Basis
The reserves for this policy are equal to or greater than those required by law. A detailed statement of the method of computing reserves has been filed with the insurance supervisory official of the state in which this policy is written.

OWNERSHIP AND BENEFICIARY

Owner

The owner of this policy is the Insured named, unless stated otherwise in the application, or later changed. The change must be approved by the company. The change will take place on the effective date shown on the endorsement provided by the compnay. If the policy is assigned, your control may be limited.The naming of an irrevocable beneficiary may also limit your control.

You may appoint a new owner if you notify us in writing. The change will take place the date you sign the notice. This is true even if the Insured dies before we receive it. The change will not affect anything we did before we receive the notice.

Beneficiary

The beneficiary is the person or persons named in the application by you to receive the Proceeds when the Insured dies. You may change the beneficiary if you notify us in writing. Any irrevocable beneficiary must agree in writing to that change. You may not have this right if the policy is assigned.

Assignment

You may assign or transfer your rights in this policy. The transfer will take effect when we receive notice of it in writing. We will record it but will not be responsible for its validity or effect.

GENERAL PROVISIONS

Contract

The contract consists of this policy, a copy of the application, and rider benefits, endorsements, or any other papers attached. All statements made in the application, except for any made to defraud us, are considered based on your present knowledge and belief. They are representations and not warranties. No statement may be used to void this policy or be used in defense of a claim unless it is in the application.

The policy may be changed only in writing and only if you and we agree. The agreement must be signed by our President or Secretary. No agent or other person may change, or waive any provision.

Incontestability

We cannot contest this policy after it has been in force, during the lifetime of the Insured, for two years from the policy date except for non-payment of premiums. This paragraph does not apply to any Waiver of Premiums or Accidental Death benefit riders.

Suicide

If the Insured dies by suicide within 2 years after the policy date, we will pay to the beneficiary no more than an amount equal to the sum of all premiums paid. This is true whether the Insured was sane or insane. If the law of the state where this policy is written provides for a shorter period, that law will govern.

Protection of Payments

Unless you and we agree to it, or unless otherwise provided in this policy, no one entitled to receive benefits under this policy may commute, pledge, sell or assign any part of such benefits. To the extent permitted by law, such benefits shall not be subject to the claims of any payee's creditors or to legal process against any payee.

Incorrect Age or Sex

If the Insured's age or sex has been misstated In the application, any amount we pay will be as the premiums paid would have purchased at the correct age and sex.

Conformity with State Laws

On the policy date, any provision of this policy in conflict with the laws of the state in which your policy was issued on that date is amended to conform with the minimum requirements of those laws.

Nonparticipation

This policy does not participate in the distribution of our surplus. As a result, no dividends will be paid under this policy.

GENERAL PROVISIONS CONTINUED

End of Policy

This policy will end on the earliest of the following:

1. the date you request it ends; or
2. the date the Insured dies; or
3. the date the Grace Period ends if sufficient premium has not been paid; or
4. the policy anniversary following the Insured's **95**th birthday.

SURRENDER BENEFITS

This policy has no surrender value or non-forfeiture benefits.

POLICY LOANS

This policy has no loan values.

TERM LIFE INSURANCE POLICY

Proceeds payable if the Insured dies while this policy is in force
Premiums payable during Premium Period or Until Insured's Prior Death
Renewable as Provided Herein
Nonparticipating

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.
All shaded areas must be completed.

Life Insurance Company of Alabama

P. O. Box 349
Gadsden, Alabama 35902

1. PROPOSED INSURED ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated LAST NAME FIRST M.I.	BIRTHDATE MO	DAY	YR	AGE	STATE OF BIRTH	SEX	SOCIAL SECURITY #	HEIGHT (FT. IN.)	WEIGHT (LBS.)
SPOUSE PROPOSED for INSURANCE									
DEPENDENT CHILDREN PROPOSED for INSURANCE									

2. RESIDENCE ADDRESS STREET	CITY	COUNTY	STATE	ZIP	How long at this address? Years Months If less than 2 years, give previous address under "Details"
3a. INSURED'S EMPLOYER			EMPLOYMENT DATE		
3b. OCCUPATION (Describe and give exact duties)			PHONE: RES: ( ) BUS: ( )		SEND MAIL TO ☐ Residence ☐ Business

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LIFE INSURANCE

TYPE PLAN	FACE AMOUNT	PREMIUM
☐ Protector *II* (Whole Life)	$_____	$_____
☐ Simplified Underwriting (Must disclose name and address of an Attending Physician.) ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements.)		
☐ 10 Year Guaranteed Level Term	$_____	$_____
☐ 15 Year Guaranteed Level Term	$_____	$_____
☐ 20 Year Guaranteed Level Term	$_____	$_____
☐ 30 Year Guaranteed Level Term	$_____	$_____

RIDERS

☐ Accidental Death Benefit	$_____	$_____
☐ Children's Term _____Units ($1,000 Coverage Per Unit)	$_____	$_____
Waiver of Premium ☐ Yes ☐ No		$_____
Automatic Premium Loan ☐ Yes ☐ No		

Total Mode Premium

$

SPECIAL REQUEST

4. PREMIUM MODE:
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

5. PREMIUM METHOD: Monthly Direct Bill **Not** Available
☐ Bank Draft ☐ Payroll Deduction ☐ Direct Billing ☐ Fam. Bill

6a. Is there any Life Insurance in force or Application pending on the life/lives of any proposed insured(s)? ☐ Yes ☐ No (If yes, complete below)
Name Company Amount Year Issued

6b. Will the policy applied for replace any insurance or annuity in force on any proposed covered person? ☐ Yes ☐ No (If yes, give name and address of company and complete the replacement form.)

6c. AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If yes, give name of company and policy number.

7a. OWNER, IF OTHER THAN PROPOSED INSURED
NAME RELATIONSHIP
STREET CITY STATE ZIP
OWNER'S SOCIAL SECURITY # OR TAX ID #
PROPOSED INSURED, IF MINOR, BECOMES OWNER: ☐ AT AGE OF MAJORITY ☐ AT OWNER'S DEATH ☐ WHEN SPECIFIED IN WRITING BY OWNER

7b. PAYOR: (if other than proposed insured)
NAME ADDRESS

HOME OFFICE ENDORSEMENTS

APPLICATION FOR LIFE INSURANCE - PART 2

8. SEND PREMIUM NOTICES AND CORRESPONDENCE TO: ☐ Insured ☐ Owner ☐ Payor

9a. Primary Beneficiary & Relationship	**9b.** Contingent Beneficiary & Relationship
9c. Spouse Primary Beneficiary & Relationship	**9d.** Spouse Contingent Beneficiary & Relationship

10. IS ANY PROPOSED INSURED currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	PROPOSED INSURED Yes ☐	PROPOSED INSURED No ☐	SPOUSE Yes ☐	SPOUSE No ☐	CHILD RIDER Yes ☐	CHILD RIDER No ☐

PROTECTOR // FACE AMOUNTS UNDER $100,000.00 ANSWER QUESTIONS 11 - 13 ONLY

	Yes	No	Yes	No	Yes	No
11. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
12. HAS ANY PERSON to be covered ever had or been told or been treated for:	Yes	No	Yes	No	Yes	No
(a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a medical professional?	☐	☐	☐	☐	☐	☐
(b) Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure?	☐	☐	☐	☐	☐	☐
(c) Disease or disorder of the nervous system to include mental disorder, epilepsy, paralysis or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(d) Disease or disorder of the respiratory system to include emphysema or asthma?	☐	☐	☐	☐	☐	☐
(e) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia?	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor, diabetes, Leukemia, gland, blood disorders or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(g) Alcohol or drug usage or abuse?	☐	☐	☐	☐	☐	☐
(h) Has any person to be covered had any medical advice, treatment, surgery or disorder not already	☐	☐	☐	☐	☐	☐
13. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	☐	☐	☐	☐	☐	☐

PROTECTOR // FACE AMOUNTS OF $100,000.00 AND OVER ANSWER QUESTIONS 14 - 19 ONLY

14. FAMILY HISTORY	Age(s) if Living *Insured*	Age(s) if Living *Spouse*	Age(s) at Death *Insured*	Age(s) at Death *Spouse*	Cause of Death *Insured*	Cause of Death *Spouse*
Father						
Mother						
Brothers						
Sisters						

	Yes	No	Yes	No	Yes	No
15. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
16. HAS ANY PERSON proposed for insurance in Part 1 on reverse side ever had or been treated for:	Yes	No	Yes	No	Yes	No
(a) Chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, indigestion or any other disease of the stomach, intestines, gall bladder or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐

APPLICATION FOR LIFE INSURANCE - PART 3

Questions for $100,000.00 and over continued	PROPOSED INSURED		SPOUSE		CHILD RIDER	
(Question 16 continued)	Yes	No	Yes	No	Yes	No
(g) Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	☐	☐	☐	☐	☐	☐
(h) Alcohol abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
17. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member with a history of diabetes, mental, nervous, heart or circulatory disorder, Tuberculosis, Cancer, High Blood Pressure, Kidney Disease or Suicide?	☐	☐	☐	☐	☐	☐
18. IS ANY PERSON proposed for insurance in Part 1 on reverse side now under observation or taking treatment or been advised to have any tests, hospitalization or surgery which has not been completed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
19. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

TERM ALL FACE AMOUNTS ANSWER QUESTIONS 20 - 24

	PROPOSED INSURED		SPOUSE		CHILD RIDER	
20. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
21. HAS ANY PERSON proposed for insurance in Part 1 on reverse side ever had or been treated for:						
(a) Chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, or any other disease of the stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
22. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member with a history of diabetes, mental, nervous, heart or circulatory disorder, Tuberculosis, Cancer, High Blood Pressure, Kidney Disease or Suicide?	☐	☐	☐	☐	☐	☐
23. IS ANY PERSON proposed for insurance in Part 1 on reverse side now under observation or taking treatment or been advised to have any tests, hospitalization or surgery which has not been completed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
24. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	☐	☐	☐	☐	☐	☐

APPLICATION FOR LIFE - PART 4

DETAILS OF questions 10-24 answered "yes" : Include question #, names and addresses of physicians and individuals to who history pertains.

AGREEMENT **Terms used In this Agreement:**

"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:

(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.

(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.

(c) Unless the policy becomes effective as specified in the conditional receipt attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.

(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.

(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.

(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?	**Home/Office Phone:** **Cell Phone:** **Email address:**

I represent that copies of all sales material have been left with the Proposed Insured.

X _____
Witness (Licensed Resident Agent, if required)

X _____
Agent Agent's No.

X _____
Agent Agent's No.

X _____
Agent Agent's No.

X _____
Agent Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured if 15 years of age or older

X _____
Signature of Spouse if 15 years of age or older

X _____
Signature of Owner or Applicant if other than proposed insured

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION TO THE LIFE INSURANCE COMPANY OF ALABAMA

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the patient, employee or deceased named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends, if not revoked before such date. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

_____	_____	_____
Applicant's Name (Please Print)	Signature of Proposed Insured	Date
_____	_____	_____
Spouse's Name (Please Print)	Signature of Spouse	Date

IMPORTANT NOTICE
INVESTIGATIVE CONSUMER REPORTS

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fare share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

Date _____ _____
Signature of Proposed Primary Insured

Date _____ _____
Signature of Spouse

Date _____ _____
Signature of Applicant or Owner, if other than Proposed Insured

THIS NOTIFICATION MUST BE DELIVERED
TO THE PERSON NAMED ABOVE.

X _____ Date _____
Signature of Agent or Broker

Life Insurance Company of Alabama
Home Office, Gadsden, Alabama

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (*PLEASE PRINT OR TYPE*)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

X _____
DATE SIGNATURE OF EMPLOYEE

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

To _____ Bank

Branch Name, if any _____

Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

X _____
Date Bank Account Bank Signature of Depositor

Cut along dotted line.

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

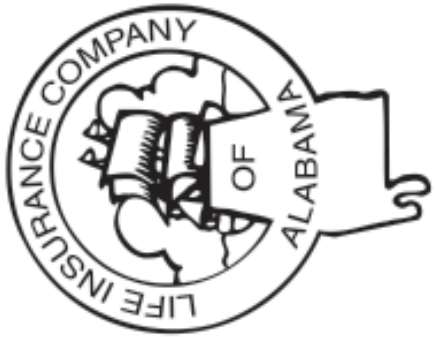
THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

Clarence W. Daugette

President

Authorized in resolution adopted by the Executive Board of The Life Insurance Company of Alabama on April 29,

Cut along dotted line.



Life Insurance Company of Alabama
302 BROAD STREET • GADSDEN, ALABAMA 35901

WAIVER OF PREMIUM DISABILITY RIDER

READ THIS POLICY CAREFULLY!

Rider Effective Date if different from Policy Date _____

This is an additional benefit to the contract of insurance between ***LIFE INSURANCE COMPANY OF ALABAMA*** and the owner of the Policy to which this Rider is attached. It has the same Effective Date as the Policy, shown on the Policy Schedule page, or the date of the Endorsement, whichever is later.

CONSIDERATION

This Rider is issued in consideration of the statements made in the application and the payment of the premium as shown on the Policy Schedule, or as shown by Endorsement. It is subject to the definitions, provisions, exceptions, and limitations of the Policy which are not inconsistent with the provisions of this Rider.

The amount of premium for this Rider is stated on the Policy Schedule page of the Policy to which this Rider is attached. The premiums for this Rider shall be due and payable on the same dates and under the same conditions as the Policy to which this Rider is attached. The premium for this Rider shall cease whenever this Rider terminates.

TERMINATION OF RIDER

This Rider will terminate on the occurrence of the first of the following events:

1. when the policy terminates, matures, is surrendered, or becomes paid-up insurance;
2. upon the death of the Insured;
3. when We receive Your Written Request for termination of this Rider at Our Home Office;
4. upon non-payment of any premium if it is not paid when due or within the Grace Period; or
5. upon the Rider Expiration Date shown on the Policy Schedule page of the Policy.

WE SIGNED this at our Home Office in Gadsden, Alabama on the Agreement Date.

Secretary

President

BENEFIT

We will waive the payment of premiums, as due, for this Policy and for any included rider(s), except annuity riders, after we receive written proof that the Insured has been Totally Disabled.

Total Disability of the Insured must begin:

1. while this Rider is in force; and
2. prior to the anniversary next following the 65th birthday of the Insured.

During the continued Total Disability of the Insured, premiums will be waived to the end of the premium period shown in the Policy Schedule for the Policy. No premiums will be waived beyond the Rider Expiration Date for this Rider as shown on the Policy Schedule page of the Policy.

DEFINITION OF TOTAL DISABILITY

For the purpose of this Rider, Total Disability means:

1. the complete and continuous inability of the Insured to engage, for a continuous period of not less than six (6) months, in his own occupation during the first year of Disability; and
2. thereafter, the complete and continuous inability to engage in any employment or occupation for which the Insured is qualified by reason of education, training or experience.

The Disability must have resulted from bodily injury or disease which first appears after the Effective Date of this Rider.

Total Disability also means the permanent and total loss of (i) the sight of both eyes, or (ii) the use of both hands, or (iii) the use of both feet, or (iv) the use of one hand and one foot occurring after the Effective Date of this Rider.

NOTICE AND PROOF OF CLAIM

We must receive notice and proof of Disability during the lifetime of the Insured. We must also receive such notice within one (1) year after Disability begins unless we are satisfied that the proof was given as soon as reasonably possible. The notice of claim should be mailed or delivered to our Home Office and should include the Insured's name and the policy number.

We may require proof that Total Disability is continuous by having the Insured examined by any doctor we designate at our expense. Examinations may be made at any reasonable interval during the first two years of Disability. After two years, we may require proof no more than once a year.

PAYMENT OF DUE PREMIUMS

Any premium that becomes due prior to the Company's receipt of notice of claim must be paid. Upon our receipt and approval of claim, we will refund all premiums due and paid after the date of Total Disability.

RISKS NOT COVERED - No premium will be waived if Disability resulted from:

1. an intentionally self-inflicted injury, or
2. an injury or disease attributable to war (declared or undeclared), or to any conflict between armed forces of any country or countries, whether or not the Insured was in military service, or
3. the commission of or attempt to commit an assault or felony, or
4. intoxication or the voluntary taking, inhaling, or absorbing any drug, medication, or sedative, unless prescribed by a doctor. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred.

GENERAL PROVISIONS

This Rider has no non-forfeiture benefits.

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification signed.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
MP LIFE 7-10.pdf

Item Status: **Status Date:**

Satisfied - Item: Authorization Letter
Comments:
Attachment:
Authorization Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR Cover Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: AR Rule 19 Certification

SERFF Tracking Number:	*WAKE-126761415*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*46444*
Company Tracking Number:	*KEGLOATLAR*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life Policy*		
Project Name/Number:	*Life Insurance Company of Alabama/KEGLOATLAR*		

Comments:

Attachment:

AR Rule 19 Certification.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Life Insurance Company of Alabama
302 Broad Street
Gadsden, AL 35901

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Term Life Insurance Policy	**LT300**	**55.9**
Waiver of Premium Disability Rider	**WP LT300**	**44.6**
Application for Life Insurance	**MP LIFE 7-10**	**40.7**

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Signature

J. Steven Keck
Name

Consulting Actuary
Title

August 9, 2010
Date

APPLICATION FOR LIFE INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.
All shaded areas must be completed.

Life Insurance Company of Alabama

P. O. Box 349
Gadsden, Alabama 35902

1. PROPOSED INSURED ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated LAST NAME FIRST M.I.	BIRTHDATE MO	DAY	YR	AGE	STATE OF BIRTH	SEX	SOCIAL SECURITY #	HEIGHT (FT. IN.)	WEIGHT (LBS.)
SPOUSE PROPOSED for INSURANCE									
DEPENDENT CHILDREN PROPOSED for INSURANCE									

2. RESIDENCE ADDRESS STREET	CITY	COUNTY	STATE	ZIP	How long at this address? Years Months If less than 2 years, give previous address under "Details"
3a. INSURED'S EMPLOYER			EMPLOYMENT DATE		
3b. OCCUPATION (Describe and give exact duties)			PHONE: RES: ( ) BUS: ( )		SEND MAIL TO ☐ Residence ☐ Business

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LIFE INSURANCE

TYPE PLAN	FACE AMOUNT	PREMIUM
☐ Protector *II* (Whole Life)	$_____	$_____
☐ Simplified Underwriting (Must disclose name and address of an Attending Physician.) ☐ E-Z Underwriting (Subject to Question 10 and Company Participation requirements.)		
☐ 10 Year Guaranteed Level Term	$_____	$_____
☐ 15 Year Guaranteed Level Term	$_____	$_____
☐ 20 Year Guaranteed Level Term	$_____	$_____
☐ 30 Year Guaranteed Level Term	$_____	$_____

RIDERS

☐ Accidental Death Benefit	$_____	$_____
☐ Children's Term _____Units ($1,000 Coverage Per Unit)	$_____	$_____
Waiver of Premium ☐ Yes ☐ No		$_____
Automatic Premium Loan ☐ Yes ☐ No		

Total Mode Premium

$

SPECIAL REQUEST

4. PREMIUM MODE:
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

5. PREMIUM METHOD: Monthly Direct Bill **Not** Available
☐ Bank Draft ☐ Payroll Deduction ☐ Direct Billing ☐ Fam. Bill

6a. Is there any Life Insurance in force or Application pending on the life/lives of any proposed insured(s)? ☐ Yes ☐ No (If yes, complete below)
Name Company Amount Year Issued

6b. Will the policy applied for replace any insurance or annuity in force on any proposed covered person? ☐ Yes ☐ No (If yes, give name and address of company and complete the replacement form.)

6c. AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If yes, give name of company and policy number.

7a. OWNER, IF OTHER THAN PROPOSED INSURED
NAME RELATIONSHIP
STREET CITY STATE ZIP
OWNER'S SOCIAL SECURITY # OR TAX ID #
PROPOSED INSURED, IF MINOR, BECOMES OWNER: ☐ AT AGE OF MAJORITY ☐ AT OWNER'S DEATH ☐ WHEN SPECIFIED IN WRITING BY OWNER

7b. PAYOR: (if other than proposed insured)
NAME ADDRESS

HOME OFFICE ENDORSEMENTS

APPLICATION FOR LIFE INSURANCE - PART 2

8. SEND PREMIUM NOTICES AND CORRESPONDENCE TO: ☐ Insured ☐ Owner ☐ Payor

9a. Primary Beneficiary & Relationship	**9b.** Contingent Beneficiary & Relationship
9c. Spouse Primary Beneficiary & Relationship	**9d.** Spouse Contingent Beneficiary & Relationship

10. IS ANY PROPOSED INSURED currently in the hospital or receiving disability payments; or, in the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	PROPOSED INSURED Yes ☐	PROPOSED INSURED No ☐	SPOUSE Yes ☐	SPOUSE No ☐	CHILD RIDER Yes ☐	CHILD RIDER No ☐

PROTECTOR // FACE AMOUNTS UNDER $100,000.00 ANSWER QUESTIONS 11 - 13 ONLY

	Yes	No	Yes	No	Yes	No
11. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
12. HAS ANY PERSON to be covered ever had or been told or been treated for:	Yes	No	Yes	No	Yes	No
(a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a medical professional?	☐	☐	☐	☐	☐	☐
(b) Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure?	☐	☐	☐	☐	☐	☐
(c) Disease or disorder of the nervous system to include mental disorder, epilepsy, paralysis or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(d) Disease or disorder of the respiratory system to include emphysema or asthma?	☐	☐	☐	☐	☐	☐
(e) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia?	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor, diabetes, Leukemia, gland, blood disorders or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(g) Alcohol or drug usage or abuse?	☐	☐	☐	☐	☐	☐
(h) Has any person to be covered had any medical advice, treatment, surgery or disorder not already	☐	☐	☐	☐	☐	☐
13. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	☐	☐	☐	☐	☐	☐

PROTECTOR // FACE AMOUNTS OF $100,000.00 AND OVER ANSWER QUESTIONS 14 - 19 ONLY

14. FAMILY HISTORY	Age(s) if Living *Insured*	Age(s) if Living *Spouse*	Age(s) at Death *Insured*	Age(s) at Death *Spouse*	Cause of Death *Insured*	Cause of Death *Spouse*
Father						
Mother						
Brothers						
Sisters						

	Yes	No	Yes	No	Yes	No
15. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:						
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
16. HAS ANY PERSON proposed for insurance in Part 1 on reverse side ever had or been treated for:	Yes	No	Yes	No	Yes	No
(a) Chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, indigestion or any other disease of the stomach, intestines, gall bladder or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐

APPLICATION FOR LIFE INSURANCE - PART 3

Questions for $100,000.00 and over continued	PROPOSED INSURED		SPOUSE		CHILD RIDER	
(Question 16 continued)	Yes	No	Yes	No	Yes	No
(g) Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	☐	☐	☐	☐	☐	☐
(h) Alcohol abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
17. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member with a history of diabetes, mental, nervous, heart or circulatory disorder, Tuberculosis, Cancer, High Blood Pressure, Kidney Disease or Suicide?	☐	☐	☐	☐	☐	☐
18. IS ANY PERSON proposed for insurance in Part 1 on reverse side now under observation or taking treatment or been advised to have any tests, hospitalization or surgery which has not been completed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
19. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

TERM ALL FACE AMOUNTS ANSWER QUESTIONS 20 - 24

	PROPOSED INSURED		SPOUSE		CHILD RIDER	
20. HAS ANY PERSON proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician?	☐	☐	☐	☐	☐	☐
(b) Had any motor vehicle moving violations or accidents within the last two years?	☐	☐	☐	☐	☐	☐
(c) Been arrested for any reason other than moving traffic violations?	☐	☐	☐	☐	☐	☐
(d) Flown other than as a fare-paying passenger within the last two years or contemplate such flying in the future? *(If yes, complete Aviation Questionnaire.)*	☐	☐	☐	☐	☐	☐
(e) Any past, present or expected activity in racing, skin or sky diving or any other sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)*	☐	☐	☐	☐	☐	☐
(f) Ever had an application for insurance or reinstatement of insurance declined, postponed, rated up or modified? Why?	☐	☐	☐	☐	☐	☐
21. HAS ANY PERSON proposed for insurance in Part 1 on reverse side ever had or been treated for:						
(a) Chest pain, heart murmur, high blood pressure or any other disease of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
(b) Peptic ulcer, or any other disease of the stomach, intestines, pancreas or liver?	☐	☐	☐	☐	☐	☐
(c) Emphysema, bronchitis, asthma, Chronic Obstructive Pulmonary Disease (COPD) or any other disease of the chest or lungs?	☐	☐	☐	☐	☐	☐
(d) Hepatitis, diabetes; albumin, pus, blood or sugar in urine; venereal disease or any other disease of the kidneys, bladder, reproductive organs or connective tissue disorder?	☐	☐	☐	☐	☐	☐
(e) Stroke, severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder or any other disease of the brain, nervous system or been treated for a back condition?	☐	☐	☐	☐	☐	☐
(f) Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐
(g) Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	☐	☐	☐	☐	☐	☐
(h) Alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
(i) Cancer, tumor or any other illness or injury not mentioned above?	☐	☐	☐	☐	☐	☐
(j) Any abnormality, deformity, disease or disorder not mentioned above?	☐	☐	☐	☐	☐	☐
22. OTHER THAN INDICATED ABOVE, has any person proposed for insurance in Part 1 on reverse side:	Yes	No	Yes	No	Yes	No
(a) Ever applied for or received a pension or disability benefit?	☐	☐	☐	☐	☐	☐
(b) Been hospitalized in the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(c) Consulted a physician during the past 5 years? If so, when and where?	☐	☐	☐	☐	☐	☐
(d) Had a change of weight in the past year?	☐	☐	☐	☐	☐	☐
(e) Had an immediate family member with a history of diabetes, mental, nervous, heart or circulatory disorder, Tuberculosis, Cancer, High Blood Pressure, Kidney Disease or Suicide?	☐	☐	☐	☐	☐	☐
23. IS ANY PERSON proposed for insurance in Part 1 on reverse side now under observation or taking treatment or been advised to have any tests, hospitalization or surgery which has not been completed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
24. HAS ANY PERSON proposed for insurance in Part 1 used tobacco in any form within the last 24 months?	☐	☐	☐	☐	☐	☐

APPLICATION FOR LIFE - PART 4

DETAILS OF questions 10-24 answered "yes" : Include question #, names and addresses of physicians and individuals to who history pertains.

AGREEMENT **Terms used In this Agreement:**

"You" and "Your" mean the Proposed Insured and the Applicant, if other than the Proposed Insured. "We", "us" and "our" mean the Life Insurance Company of Alabama. It is understood and agreed by you that:

(a) Any policy issued as a result of this application shall constitute a single and entire contract of insurance. Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company may make a contract on its behalf. No waiver or modification of a contract provision or any of the Company's rights or requirements shall be binding upon the Company unless it is in writing signed by one of such officers. NEITHER THE AGENT WHOSE SIGNATURE APPEARS BELOW, NOR ANY OTHER AGENT OR BROKER, NOR ANY MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, MAKE OR MODIFY CONTRACTS OR WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.

(b) To the best of your knowledge and belief all of the statements and answers on this application are true, complete and correctly stated. These statements and answers are offered to us as the basis for any policy issued on this application.

(c) Unless the policy becomes effective as specified in the conditional receipt attached to this application, we will incur no liability until (1) any policy applied for has been delivered to and accepted by you and (2) the first premium is paid. When you accept the policy, the state of health of the Proposed Insured and/or Applicant or any other factor affecting insurability must be the same as set forth in the application.

(d) Acceptance of the policy issued based on this application will be an acceptance of its terms and ratifications of any changes specified in the section marked "Home Office Endorsements". Any change in plan or amount of insurance, premium, classification or added benefits must be agreed to in writing.

(e) No Agent Broker or Medical Examiner can accept risks or waive any of our requirements, nor can the Agent, Broker or Medical Examiner make or alter contracts. Notice to or knowledge imputed to any Agent, Broker, Medical Examiner will not be notice to or knowledge of us unless it is set out in writing in this application.

(f) Any life insurance issued as a result of this application shall be owned by the applicant or by person(s) who receive ownership from the applicant.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?	**Home/Office Phone:** **Cell Phone:** **Email address:**

I represent that copies of all sales material have been left with the Proposed Insured.

X _____
Witness (Licensed Resident Agent, if required)

X _____
Agent Agent's No.

X _____
Agent Agent's No.

X _____
Agent Agent's No.

X _____
Agent Agent's No.

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Insured if 15 years of age or older

X _____
Signature of Spouse if 15 years of age or older

X _____
Signature of Owner or Applicant if other than proposed insured

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION TO THE LIFE INSURANCE COMPANY OF ALABAMA

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

Physician/Hospital Names _____

Address _____ Phone # _____

Conditions _____Dates of Service _____

Special Instructions: _____

I hereby authorize the above person(s) or entity(s) listed in above and the Medical Information Bureau and any prescription drug or pharmacy organization(s) to provide **Life Insurance Company of Alabama**, or to **Lab One/Exam One** on the behalf of Life Insurance Company of Alabama, information, data, or records concerning advice, care, treatment or health history provided to the patient, employee or deceased named above, including, but not limited to, notes, reports, test results, x-rays, documents related to any mental conditions, cost of medical services, prognosis, physician notes of patient interviews, patient notes or other data and including the full and complete clinical records, hospital charts, examination records and medical history I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition; information relating to HIV testing, HIV status, or AIDS. I understand that such information may be subject to special protections pursuant to law and that by signing this authorization, I authorize the person(s) or entity(s) listed to disclose records containing such information. Please list any special instructions. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at: *Life Insurance Company of Alabama, Attn: Privacy Official, PO Box 349, Gadsden, AL 35902*. I understand that the revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my insurance coverage ends, if not revoked before such date. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

_____	_____	_____
Applicant's Name (Please Print)	Signature of Proposed Insured	Date
_____	_____	_____
Spouse's Name (Please Print)	Signature of Spouse	Date

IMPORTANT NOTICE
INVESTIGATIVE CONSUMER REPORTS

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fare share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided. **You or any person authorized to act on your behalf are entitled to receive a copy of this Authorization Form.**

Date _____ _____
Signature of Proposed Primary Insured

Date _____ _____
Signature of Spouse

Date _____ _____
Signature of Applicant or Owner, if other than Proposed Insured

THIS NOTIFICATION MUST BE DELIVERED
TO THE PERSON NAMED ABOVE.

X _____ Date _____
Signature of Agent or Broker

Life Insurance Company of Alabama
Home Office, Gadsden, Alabama

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (*PLEASE PRINT OR TYPE*)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

X _____
DATE SIGNATURE OF EMPLOYEE

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

To _____ Bank

Branch Name, if any _____

Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

X _____
Date Bank Account Bank Signature of Depositor

Cut along dotted line.

To: The Bank named on the reverse side.

The Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

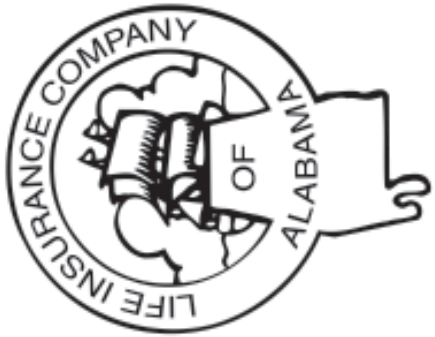
THE LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

Clarence W. Daugette

President

Authorized in resolution adopted by the Executive Board of The Life Insurance Company of Alabama on April 29,

Cut along dotted line.



LIFE INSURANCE COMPANY of Alabama

HOME OFFICE
P. O. BOX 349
GADSDEN, ALABAMA 35902
Phone: (256) 543-2022

June 29, 2010

Wakely Actuarial Services, Inc.
34125 US Highway 19 North, Suite 310
Palm Harbor, Florida 34684

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit forms, rate filings or other filings requiring actuarial certification for approval to the Department of Insurance on behalf of Life Insurance Company of Alabama. Revisions to the filings, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Clarence W. Daugette, III
President

CWDIII/js

August 9, 2010

State of Arkansas
Department of Insurance

RE: Company: Life Insurance Company of Alabama
NAIC Number: 65412
FEIN Number: 63-0321291
Type of Insurance: Individual Life – Term
Sub-Type: Single Life – Fixed Premium

Forms Submitted For Approval

A. New Forms Replacing Previously Approved Forms

Form Number	Description	Replaces Form	Approved
LT300	Term Life Insurance Policy	2004 LT 220	12-08-04
MP LIFE 7-10	Application for Life Insurance	MP LIFE 8-00 rev. 8-04	11-16-04

B. New Rider Forms

Form Number	Description
WP LT300	Waiver of Premium Disability Rider

Dear Sir or Madam:

Wakely Actuarial Services Inc. ("Wakely") is submitting the above-referenced forms for review and approval on behalf of Life Insurance Company of Alabama ("the Company"). A letter from the Company authorizing Wakely to conduct this filing is included with this submission. Also enclosed are actuarial memoranda, Flesch score certifications, and any other required certifications and/or transmittals. Filing fees if applicable are submitted under separate cover.

We are filing these forms in 10 states including our domicile state of Alabama. Upon approval, the product will be marketed to individuals by career agents and independent brokers licensed with Life of Alabama. The product may also be used in the payroll deduction market.

These forms may be subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. We certify that the text content of the forms will not change. Variable data or text is bracketed and a variability statement is enclosed. Variable data will never exclude provisions required by applicable law.

Form LT300 is a level death benefit term life insurance policy providing coverage to the policy anniversary following the insured's age 95. Premiums for an initial term period are level. Following the initial term period, premiums will increase annually to the final expiry date. Four initial term period options are available: 10 Years, 15 Years, 20 Years, or 30 Years. Premiums are both sex-distinct and smoker-distinct; and are fully guaranteed in all years. Available issue ages vary depending upon the length of the initial term period so that the policy does not generate.

The following optional riders, previously approved by your Department, may also be used with this policy form:

Form Number	Description	Approved
2004 ADB	Accidental Death Benefit Rider	11-16-04
2004 CDB2	Children's Term Rider	11-16-04

Wakely Actuarial Services Inc. greatly appreciates the Department's time and consideration in the review of this filing. If you have any questions or need any further information, please call me on our toll free line at 1-888-590-5504.

Sincerely,

Katlyn Gorman
Administrative Assistant

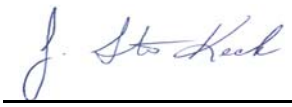
EMAIL Address: Katlyn.Gorman@wakelyactuarial.com

Enclosures

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Term Life Insurance Policy	LT300
Waiver of Premium Disability Rider	WP LT300
Application for Life Insurance	MP LIFE 7-10

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.



Signature

J. Steven Keck
Name

Consulting Actuary
Title

August 9, 2010
Date